

**COLUMBIA COMMUNITY MENTAL HEALTH
MEDICAL DATA BASE**

NAME: _____ Age: _____ Sex: _____ Hgt: _____ Wgt: _____ Date: _____

Daytime phone # _____ Zip Code: _____

Family Physician: _____ Phone # _____ Date of last exam: _____

Illnesses and Disorders

	Self	Related Family		Self	Related Family
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid disorder	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cirrhosis	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>
Stomach Pain	<input type="checkbox"/>	<input type="checkbox"/>	Bowel problems	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Substance Abuse	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>		Other	<input type="checkbox"/>	<input type="checkbox"/>

Please explain:

Do you have problems with the following:

- Hearing Vision Dental Ambulation
 Sleep Diet Sexual Menstrual periods

Please explain:

Current Medications Dose Frequency Prescribed by *(name of physician.)*

Are you allergic to any medications? Yes No If yes please list name: _____

Symptoms of Allergy:

History of seizure? Yes No Date of last Seizure:_____ Frequency of seizures:_____

Describe your seizures: _____

Hospitalizations:

Hospital name or address:	Date	Reason	Physician
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Children Only:

If yes please explain:

Were there problems with the birth? Yes No _____
Were there concerns with the pregnancy? Yes No _____
Were there health concerns after birth? Yes No _____

Substance use:

Tobacco? Smoke Chew Neither Number of years? _____ How many per day? _____
Persistent cough or shortness of breath? Yes No
Sores in mouth? Yes No

Do you drink caffeinated beverages? Yes No Amount per day _____

Do you drink alcohol? Yes No Amount per day _____ week _____ month _____

Do you use marijuana? Yes No As prescribed Amount per day _____ month _____

Do you use other drugs? [Including misusing prescribed drug?] Yes No What drug? _____
How? IV Inhale Pills Smoke

Have you abused drugs or alcohol in the past? (Please explain): _____

Have you ever had blackouts? Yes No (Please explain): _____

Please list and explain any other medical concerns you may have: _____

MEDICAL REVIEWER: _____ DATE: _____

Comments: _____